



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS HEALTH PRESBYTERIAN HOSPITAL DALLAS
3255 W PIONEER PKWY
PANTEGO TX 76013-4620

Respondent Name

LIBERTY INSURANCE CORPORATION

Carrier's Austin Representative Box

Box Number 1

MFDR Tracking Number

M4-12-1805-01

MFDR Date Received

January 26, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have found in this audit you have not paid what we determine as a amount for these outpatient services. . . . The balance due is \$6,965.96."

Amount in Dispute: \$4,586.82

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CPT Code 25999 was billed when a code exists for the procedure performed. . . . I am not clear where the provider is stating an outlier exists In performing the calculation for this providers OPPS reimbursement, implant charges under re venue code 278 cannot be included to determine if an outlier exists when you are already requesting separate implant reimbursement. The charge must be deducted from the billed charges if the provider is requesting separate implant reimbursement; otherwise, the provider would be receiving double reimbursement."

Response Submitted by: Liberty Mutual Insurance, 303 Jesse Jewell Parkway SE, Suite 500, Gainesville Georgia, 30501

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
June 22, 2011	Outpatient Hospital Services	\$4,586.82	\$4,586.82

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.

3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - X936 – CPT OR HCPC IS REQUIRED TO DETERMINE IF SERVICES ARE PAYABLE. (X936)
 - X901 – DOCUMENTATION DOES NOT SUPPORT LEVEL OF SERVICE BILLED. (X901)
 - Z652 – RECOMMENDATION OF PAYMENT HAS BEEN BASED ON A PROCEDURE CODE WHICH BEST DESCRIBES SERVICES RENDERED. (Z652)
 - Z710 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE. (Z710)
 - X133 – THIS CHARGE WAS NOT REFLECTED IN THE REPORT AS ONE OF THE PROCEDURES OR SERVICES PERFORMED. (X133)
 - U634 – PROCEDURE CODE NOT SEPARATELY PAYABLE UNDER MEDICARE AND OR FEE SCHEDULE GUIDELINES. (U634)

Issues

1. Did the respondent support the insurance carrier's reasons for reduction or denial of services?
2. Are the disputed services subject to a contractual agreement between the parties to this dispute?
3. What is the applicable rule for determining reimbursement for the disputed services?
4. What is the recommended payment amount for the services in dispute?
5. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied disputed services with reason code X901 – "DOCUMENTATION DOES NOT SUPPORT LEVEL OF SERVICE BILLED. (X901)" The respondent's position statement asserts that "CPT Code 25999 was billed when a code exists for the procedure performed." Per *Medicare Claims Processing Manual*, CMS Publication 100-04, Chapter 4, §180.3, "Under the OPPS, CMS generally assigns the unlisted service or procedure codes to the lowest level APC within the most appropriate clinically related series of APCs. Payment for items reported with unlisted codes is often packaged. . . . However, if it is determined that an unlisted code was submitted in error because the procedure or service is described by a specific HCPCS code, the contractor shall advise the hospital or CAH of the appropriate code and process the claim." Review of the submitted information finds that the respondent did not submit documentation to support that an alternate code exists for the procedure performed. No documentation was found to support that the insurance carrier notified the hospital of the alleged appropriate code. Furthermore, per 28 Texas Administrative Code §133.3(a), "Any communication between the health care provider and insurance carrier related to medical bill processing shall be of sufficient, specific detail to allow the responder to easily identify the information required to resolve the issue or question related to the medical bill." No documentation was found to support that the insurance carrier communicated this denial reason to the health care provider with sufficient, specific detail to allow the responder to easily identify the information required to resolve the issue or question related to the medical bill. Moreover, per 28 Texas Administrative Code §133.307(d)(2)(B), effective May 25, 2008, 33 *Texas Register* 3954, "The response shall address only those denial reasons presented to the requestor prior to the date the request for MDR was filed with the Division and the other party. Any new denial reasons or defenses raised shall not be considered in the review." No documentation was submitted to support that, prior to the date the request for MDR was filed, the insurance carrier ever presented to the requestor a defense or reason for denying the disputed service based on the assertion that an, allegedly, more appropriate code existed for the disputed service. Accordingly, this newly raised defense or denial reason shall not be considered in this review. The Division concludes that the respondent has not supported the insurance carrier's reason for denial of the disputed service. The disputed service will therefore be reviewed per applicable Division rules and fee guidelines.
2. Review of the submitted documentation finds no information to support that the disputed services are subject to a contractual agreement between the parties to this dispute.
3. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested. The respondent argues that "I am not clear where the

provider is stating an outlier exists. In performing the calculation for this provider's OPPS reimbursement, implant charges under revenue code 278 cannot be included to determine if an outlier exists when you are already requesting separate implant reimbursement. The charge must be deducted from the billed charges if the provider is requesting separate implant reimbursement; otherwise, the provider would be receiving double reimbursement." As the health care provider has not requested separate reimbursement of implantables, §134.403(f)(1)(B) and §134.403(f)(2) are not applicable. The facility's charges are not reduced by the billed charges for implantable items, and the Medicare facility specific reimbursement amount including outlier payments is multiplied by 200 percent.

4. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published annually in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
 - Procedure code L3670 represents an orthotic device paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to the *Medical Fee Guideline for Professional Services*, §134.203(d)(1). Per CMS *Manual System*, CMS Publication 100-20, Transmittal 833, the 2011 Texas fee listed for procedure code L3670 is \$97.17. 125% of this amount is \$121.46. The recommended payment is \$121.46.
 - Procedure code C1713 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
 - Procedure code 36415 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the *Medical Fee Guideline for Professional Services*, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$3.00. 125% of this amount is \$3.75. The recommended payment is \$3.75.
 - Procedure code 85014 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the *Medical Fee Guideline for Professional Services*, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$3.33. 125% of this amount is \$4.16. The recommended payment is \$4.16.
 - Procedure code 85018 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the *Medical Fee Guideline for Professional Services*, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$3.33. 125% of this amount is \$4.16. The recommended payment is \$4.16.
 - Procedure code 76000 has a status indicator of Q1, which denotes STVX-packaged codes; payment for these services is packaged into the payment for any other procedures with status indicators S, T, V, or X that are billed for the same date of service. This code may be separately payable only if no other such procedures are billed for the same date. Review of the submitted information finds that OPPS criteria for separate payment have not been met. Payment for this service is included in the payment for other procedures billed on the same date of service. The use of a modifier is not appropriate. Separate reimbursement is not recommended.
 - Procedure code 25999 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T APC is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. This service is classified under APC 0129, which, per OPPS Addendum A, has a payment rate of \$108.73. This amount multiplied by 60% yields an unadjusted labor-related amount of \$65.24. This amount multiplied by the annual wage index for this facility of 0.9716 yields an adjusted labor-

related amount of \$63.39. The non-labor related portion is 40% of the APC rate or \$43.49. The sum of the labor and non-labor related amounts is \$106.88. Per *Medicare Claims Processing Manual*, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator (SI) of S or T and any lines with an SI of S or T have less than \$1.01 as charges, charges for all S and/or T lines are summed and the charges are then divided across S and/or T lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This bill has a status indicator T line item with a charge of \$0.00. The APC payment for this service of \$53.44 divided by the sum of all surgical APC payments of \$2,236.43 is 2.39%, multiplied by the sum of all S and T line charges of \$15,170.25, yields a new charge amount to be used for the purpose of outlier calculation in the amount of \$362.50. This amount multiplied by the cost-to-charge ratio for this provider and added to the allocated portion of packaged costs results in a total cost for this line item that does not exceed the annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total APC payment for this service, including multiple procedure discount, is \$53.44. This amount multiplied by 200% yields a MAR of \$106.88.

- Procedure code 20900 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T APC is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. This service is classified under APC 0050, which, per OPPI Addendum A, has a payment rate of \$2,220.83. This amount multiplied by 60% yields an unadjusted labor-related amount of \$1,332.50. This amount multiplied by the annual wage index for this facility of 0.9716 yields an adjusted labor-related amount of \$1,294.66. The non-labor related portion is 40% of the APC rate or \$888.33. The sum of the labor and non-labor related amounts is \$2,182.99. Per 42 Code of Federal Regulations §419.43(d) and *Medicare Claims Processing Manual*, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPI payment and also exceeds the annual fixed-dollar threshold of \$2,025, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPI payment. If a claim has more than one surgical service line with a status indicator (SI) of S or T and any lines with an SI of S or T have less than \$1.01 as charges, charges for all S and/or T lines are summed and the charges are then divided across S and/or T lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This bill has a status indicator T line item with a charge of \$0.00. The APC payment for this service of \$2,182.99 divided by the sum of all surgical APC payments of \$2,236.43 is 97.61%, multiplied by the sum of all S and T line charges of \$15,170.25, yields a new charge amount to be used for the purpose of outlier calculation in the amount of \$14,807.75. Per the OPPI Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.274. This ratio multiplied by the revised line charge yields a cost of \$4,057.32. The total cost of all packaged items is allocated proportionately across all separately paid OPPI services based on the percentage of the total APC payment. The APC payment for this service of \$2,182.99 divided by the sum of all APC payments is 97.61%. The sum of all packaged costs is \$4,278.33. The allocated portion of packaged costs is \$4,176.10. This amount added to the service cost yields a total cost of \$8,233.42. The cost of this service exceeds the annual fixed-dollar threshold of \$2,025. The amount by which the cost exceeds 1.75 times the OPPI payment is \$4,413.19. 50% of this amount is \$2,206.60. The total APC payment for this service, including outlier payment, is \$4,389.59. This amount multiplied by 200% yields a MAR of \$8,779.17.
- Procedure code J1170 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code J2001 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code J2250 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code J2270 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code J2405 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code J3010 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code J3370 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code J7120 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.

- Procedure code 93005 is unbundled from other services billed. Per Medicare policy, payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.
5. The total allowable reimbursement for the services in dispute is \$9,019.58. The amount previously paid by the insurance carrier is \$2,477.98. The requestor is seeking additional reimbursement in the amount of \$4,586.82. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$4,586.82.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of \$4,586.82, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

_____	Grayson Richardson	October 29, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.